Caring Communities — Healthier People

Central **LHIN – 2006/07 Annual Report**

Ontario

Central Local Health Integration Network (8)
Réseau local d'intégration des services de santé du Centre (8)
Legend / Légende
Ontario
Published August 2005
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Publié août 2005
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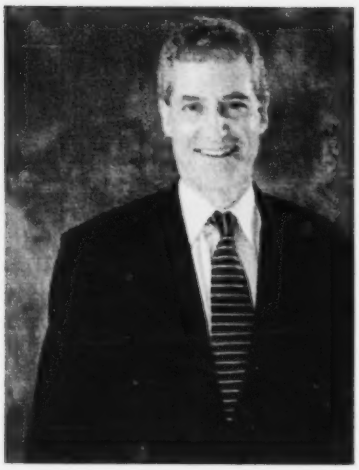
The Local Health Services Integration Act, passed in March 2006, is intended to provide an integrated health system to improve the health of Ontarians through better access to high quality health services, coordinated health care and effective and efficient management of the health system at the community level by local health integration networks (LHINs). LHINs are responsible for planning, integrating and funding health care providers (hospitals, long-term care homes, community support services, community health centres, Community Care Access Centres and community mental health and addictions agencies) in their specific geographic areas.

Message from the Chair and CEO



Laying the Foundation of Dynamic Change

The formation of our Integrated Health Service Plan defined the past year as one of development and engagement. Much of our activity throughout the year was foundational, building our capacity to assume our responsibilities for planning, coordinating, integrating and funding health services.

We began the year by reaching out to our diverse communities of health care providers and the public, to build a knowledge base from which to move forward. We spoke with hundreds of people to gain a more in-depth understanding of the health care needs across our geography. These were the footings of our foundation.

We heard from people of all ages and across diverse demographics representing people from different faiths, ethnocultural communities, and socio-economic backgrounds. We spoke with physicians from across our geography. While they do not fall directly within our integration mandate, we identified them as key enablers of integrating the local health system. We met with unions to understand how labour issues impact upon the system. And we met with representatives from each of our health service providers and the more than 140 programs they provide under the LHIN mandate.

The hundreds of discussions and thousands of individual ideas and pieces of information became the bricks from which our plan was built. Because it was important for us to build a plan that was robust, durable and credible, we again invited input on our draft plan from our community to ensure that it reflected their perspectives and needs.

This extensive knowledge-gathering process taught us an enormous amount about our communities. In particular, it helped us to identify the seven planning priorities that would best meet the needs of the people in our communities.

And while our first Integrated Health Service Plan was released in October, we see this as a major step along our journey toward a more integrated health system – our Plan is not so much a product, but a process. Throughout the implementation and refinement of our plan, we will continue to engage with our communities and evolve the plan to address the needs of a dynamically changing local health system. It is a house built upon an expansive landscape with room for growth and a clear view of the horizon.

In fact, since the Integrated Health Service Plan was released, we have worked to strengthen our foundation further, forming advisory networks comprising a broad range of stakeholders to address each of the seven planning priorities. Most of those have a variety of working groups to foster even more input from the community to lead us forward.

As the year closed out, we prepared to assume our responsibilities for planning, coordinating, funding and integrating health services in our area as the Ministry of Health and Long-Term Care passed that role onto us on April 1, 2007. Significant preparation went into ensuring that the coming year will be successful and that the Central LHIN is well positioned to formally and officially implement the Integrated Health Service Plan.

During our first full year of operation we have achieved many things, including significant high-level accomplishments:

- We engaged our stakeholders and communities in an interactive, ongoing dialogue about local health system needs through a series of community consultations, roundtables and open houses, thus enabling us to build our plan to respond to local needs.
- We Engendered Collaborative Thinking: During this past year, we began to see a shift from organization-centric to system thinking. Providers are thinking differently and working together to plan a local health system.
- We Moved Discussion into Action: Advisory Groups were formed and began planning together, contributing to system level goals and objectives to put the plan into action. Examples include the career fair and wait times collaboration with hospitals and the community sector working together.
- We Created an Organization: We established the infrastructure of the organization – office, staffing, procedures, resources – to move into our first operational year.

With the help of many, we have laid a solid foundation upon which our plans can proceed forward in the coming year and beyond. In addition to our stakeholders and communities who we engaged in helping us to lay this foundation, we would on behalf of the members of the Board of the Central LHIN, also like to acknowledge and thank our staff and the Ministry of Health and Long-Term Care.

Ken Morrison
Board Chair, Central LHIN

Hy Eliasoph
CEO, Central LHIN

Board of Directors

Kenneth A. Morrison, Chair

Tenure: June 2, 2005 — June 1, 2008
Location: Newmarket
Committee/Work Group Responsibilities:

- LHIN Officer
- End-of-Life
- Governance Councils
- LHIN Chairs Group

Ken Morrison is president of R.V. Anderson Associates Limited, a consulting firm engaged in the provision of professional engineering, operations and management services for infrastructure and environmental projects. Morrison had a long association with the North York General Hospital. He joined the hospital's foundation board of governors in 1991, serving as chair of the planned giving committee, and then as treasurer and finance committee chair. In 1994, Morrison joined the hospital's board of governors and served as Vice-Chair from 1996 to 2000, before being elected to serve as Chair from 2000 to 2005.

Arthur W. Walker, FCA, Vice-Chair

Tenure: June 2, 2005 — June 1, 2008
Location: Bradford
Committee/Work Group Responsibilities:

- Accountability Agreements
- Knowledge Transfer
- Performance Framework
- Local Scorecard
- CLHIN/IHSP Scorecard
- Funding – Decision Framework for Strategic Investment

Arthur Walker continues a long-established senior governance role in the delivery of health care in the Province of Ontario. He is a former Governor and Treasurer of the Brantford General Hospital; a former Governor and Chairman of Toronto's North York General Hospital; a former Chairman of the North York General Hospital Foundation; and prior to his appointment as Vice-Chair of Central LHIN was Director of the Southlake Regional Health Centre and of the Southlake Residential Care Village in Newmarket, Ontario. He has had broad experience as Chair, CEO, Director of numerous public and private companies - currently serving as Chairman of the Board of Calyx Transportation Group Inc., Chairman of the Board of Creditz Inc., and as a Director of CEO America Inc., and CEO UK Inc.

Sandy Keshen, Board Secretary

Tenure: June 2, 2005 — June 1, 2008
Location: Richmond Hill
Committee/Work Group Responsibilities:

- Long-Term Care (incl. Wait Times and Alternate Levels of Care)
- Mental Health and Addictions
- Neurological Services
- Health Human Resources
- Diversity and Inclusiveness
- Aboriginal

Sandy Keshen is President and CEO of Reena, a social services agency that supports individuals with developmental disabilities and their families to be fully integrated into the community. Keshen is Co-Chair of the Ontario Partnership on Aging and Developmental Disabilities. She has served as Chair of the Metro Agencies Representative Council and Chair of the Ontario Association on Developmental Disabilities. Keshen was also a board member at Whitby Psychiatric Hospital, and a member of the Vaughan Hospital Task Force.

Colin Benjamin

Tenure: January 5, 2006
— January 4, 2008
Location: North York
Committee/Work Group Responsibilities:

- Seniors and Specialized Geriatric Services
- Long-Term Care (incl. Wait Times and Alternate Levels of Care)
- Access and Coordination
- Quality

Colin Benjamin is currently the Chair of CareWatch Toronto, a voluntary organization dedicated to ensuring the quality of community-based long-term care. Prior to his retirement, he served as Assistant Vice-President, Research Administration at the University Health Network. He holds a Masters of Health Services Administration from University of Kings College/ Canadian School of Management. He is a member of the Canadian College of Health Executives and the Society of Research Administrators. He has served on the City of North York Board of Health and North York Community Care Access Centre Board of Directors. He has been the recipient of a WHO Fellowship to the Armed Forces Institute of Pathology, Washington DC; the Editor's Award of the Journal of Histotechnology; and Surgipath Canada Award of Excellence.

Anne Marie Dalimonte

Tenure: January 5, 2006
— January 4, 2008
Location: Woodbridge
Committee/Work Group Responsibilities:

- Mental Health and Addictions

Anne Marie Dalimonte was Vice President of a retail food chain for 17 years. For the past 11 years, she has served as the Executive Director of a not-for-profit day care organization which serves over 500 families. Her involvement in community affairs reflects her wide range of interests: president of a parent-teacher association, vice-president of a figure skating club, and membership in her local ratepayers' organization. A graduate in business, she was one of just 25 Canadian representatives at the Duke of Edinburgh's Commonwealth Study Conference in 1992.

Monique Moreau

Tenure: January 5, 2006
— February 4, 2010
Location: Everett
Committee/Work Group Responsibilities:

- Family Physicians

Monique Moreau has practiced family medicine in Alliston since 1997. Other activities include being a coroner, surveying for Canadian Council on Health Services Accreditation, and being an examiner for the College of Family Physicians of Canada. Previous experience includes teaching family medicine at the University of Toronto and being a preceptor for allied health trainees. Board experience includes Stevenson Memorial Hospital from 2003 to 2006, as well as St. Michael's Homes, Toronto, and Les Residences Lyne Ferguson in New Brunswick.

Raksha Bhayana

Tenure: May 17, 2006
— May 16, 2008
Location: Thornhill
Committee/Work Group Responsibilities:

- Diversity and Inclusiveness
- Communications
- Aboriginal

Raksha Bhayana is Principal of Bhayana Management and is responsible for managing investment portfolios of related companies. Prior to this, she was Director of Business Development and Information Systems at Inscape, Director of Professional Services at Family Service Association of Toronto and held various positions at Dellcrest Children's Centre, including Director of the Child and Family Clinic. Bhayana currently sits on the Board of Trustees for the United Way of Greater Toronto. She has served as a

community member of the Operations Committee for York Central Hospital, Toronto Steering Committee for the Ontario Early Years Centres and on the boards of the Family Service Association, Surrey Place Centre and the Ontario Association of Professional Social Workers. She holds a Master of Social Work from the University of Delhi (India).

Eugene Cawthray

Tenure: May 17, 2006 — June 16, 2010
Location: King City
Committee/Work Group Responsibilities:
- Neurological Services
- Information Management/ Information Technology/e-Health
- Audit (Chair)

Eugene Cawthray is President of Cawthray and Associates Inc., advising companies on their business development strategies. His current assignments are with EDS Canada, a technology management and outsourcing firm. Prior to this, he served as a special advisor for procurement transformation with the Federal Government in Ottawa. Cawthray has also held executive positions at IBM Canada Ltd., Enlogix Inc. and INTRIA Corp. He has served on the boards of York Central Hospital and of the Canadian National Institute for the Blind (CNIB) in Ontario, acting as Chair for two years. Today, he also serves on the Pension Advisory Committee for the CNIB.

Elaine Walsh

Tenure: June 17, 2006 — June 16, 2010
Location: Unionville
Committee/Work Group Responsibilities:
- Chronic Disease
- Health Human Resources
- Family Physician Advisory Group

Elaine Walsh held several positions at the Scarborough Hospital from 1999 to 2005 including Associate Director of Family Medicine and Community Services, Director of Diabetes in-patient and out-patient Programs, Director of Disease Prevention and Health Promotion, and Director of Patient Education. Prior to this, she worked for the York Region Health Department as Manager of Adolescent Health and School Program. In addition, she has worked at the Scarborough Grace Hospital as director of The Family Wellness Centre, and the York Region District Health Council as a health planner. Walsh has served on various committees and boards including Canada Prenatal Nutrition Program, Scarborough Program Advisory Committee, York Region Child Poverty Action Group and Addiction Services for York Region. She was also a founding volunteer of the Hospice Markham Stouffville. She holds a Bachelor of Science in Nursing from McGill University and a Master of Education from the University of Toronto. She is a member of the College of Nurses of Ontario.

Annual Board Remuneration

The aggregate remuneration for members of the Board of Directors for fiscal 2006/07 was $110,935.

Conflict of Interest

The Conflict of Interest Commissioner has provided the following statement to the LHIN:

"All nine Board members of the Central LHIN met with a Conflict of Interest Commissioner in 2006/07 and completed their declarations. The Conflict of Interest Commissioner provided advice in accordance with the LHIN Conflict of Interest Policy."

Our Population

Knowledge of the geography, population, health status and health services in the Central LHIN was critical over the past fiscal year to identifying priority issues for planning and resource allocation. As part of the development of our Integrated Health Service Plan, we undertook an extensive environmental scan to understand our population and their needs.

The Geography We Serve

The Central LHIN boundaries include the northern section of the City of Toronto, most of York Region and southern Simcoe County. With a population over 1.6 million, the Central LHIN is the most populous LHIN in the province. The population resides primarily in North Toronto and southern York Region. The LHIN retains a significant rural character in the north. This geographic variability provides strengths and poses challenges to planning and delivering services.

"The Central LHIN has the highest proportion of immigrants in the province."

The Central LHIN is one of the fastest growing regions in the province with an annual growth rate of 3.3 per cent over the last 10 years. This means that, on average, over the last 10 years, the population has increased by 106 new residents (through birth or immigration) every day. Over the next 10 years, the population of the Central LHIN will continue to grow, and will also grow older.

The Central LHIN has the highest proportion of immigrants in the province, almost twice the provincial average of visible minorities and a higher percentage of people whose mother tongue is not French or English. There is a relatively small presence of Aboriginal/First Nations and Francophone populations. Within the Central LHIN, North Toronto, Markham and Vaughan are the most likely areas to face challenges providing culturally and linguistically appropriate services for their diverse communities.

Population Health Profile

In general, the health status of Central LHIN residents compares favourably to those in the rest of the province. There is a lower prevalence of heavy smokers, heavy drinkers, overweight individuals and people reporting daily life stress. There is also a lower prevalence of chronic conditions such as arthritis, high blood pressure, asthma, heart disease and diabetes.

Although the Central LHIN's overall health status is relatively good, as the LHIN population ages, there will be more people with chronic conditions and the associated changes in service needs. Furthermore, residents will require expanded services to meet the population growth needs in the future. The healthy population profile is reflected in better life expectancy, and lower hospitalization and mortality rates than much of the province. The death and hospitalization

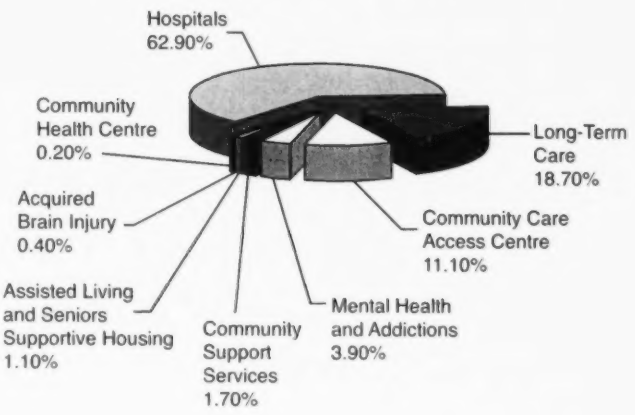
rates in a community are greatly influenced by the age and gender structure of a population. The Central LHIN hospitalization and death rates are considerably lower than the province. These lower rates are to be expected, given the Central LHIN's younger population.

Health Services

In the Central LHIN, there were 148 health care programs that received funding from the Ministry of Health and Long-Term Care in fiscal 2006/07 and that fall under the LHIN mandate. The health programs include ten hospitals (three private), 47 long-term care homes, 29 community support services, one Community Health Centre (and one in development), one Community Care Access Centre, three acquired brain injury programs, 27 mental health programs, seven substance abuse programs, five mental health supportive housing programs, one problem gambling program, five programs receiving outpatient medical salaries (sessional fees) and 12 assisted living services in supportive housing. There are also a significant number of Ministry funded services in the Central LHIN not under the LHIN mandate, including most physician services, drug benefits, independent health facilities, laboratories, ambulance services and public health.

There is a strong interdependency between the Central LHIN and other LHINs: on the one hand, the Central LHIN serves a large proportion of patients who reside outside the LHIN, and on the other hand, a large proportion of Central LHIN residents receive care from outside the LHIN. Over time it is anticipated that, through inter-LHIN planning, the provision of health services will be aligned more closely with the health needs of the population.

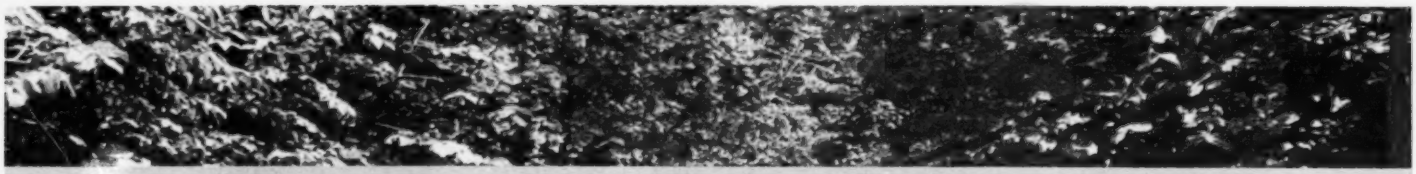
Funding and Allocation for fiscal 2006-2007



Aboriginal Health Issues

In Canadian society, there is a tendency to view Aboriginal populations as a homogenous group. However, Aboriginal people represent a culturally and linguistically diverse population. According to the 2001 Census, there were approximately 4,600 people who reported identifying with one or more Aboriginal group in the Central LHIN. These include: North American Indian, Métis, Inuit, and/or those who reported they were members of an Indian Band or First Nation.

Aboriginal populations experience some of the highest rates of poverty and ill health across Canada. Aboriginal people rate lower on all educational attainment indicators, and their unemployment rate is almost two times higher than the non-Aboriginal Ontario population. The prevalence of self-reported chronic conditions is higher than in the general population for all age groups and both genders, with the age-standardized prevalence of diabetes among Aboriginals approximately three times that of the general population. The life expectancy at birth for Aboriginal people is estimated to be six to seven years less than the general population for both sexes.



Objectives and Accomplishments

Performance

The Central LHIN's accomplishments over the past fiscal year have been significant. During this period of growth and extensive public engagement, the Central LHIN has successfully met all of its performance targets as described in our 2006/2007 Accountability Agreement with the Ministry of Health and Long-Term Care.

Throughout the year, we have staffed up to a level sufficient for us to effectively begin the implementation of our Integrated Health Service Plan.

Of note is that the Central LHIN population perceives an improvement in the health care system over the past five years. The Ministry of Health and Long-Term Care's Primary Care Access Survey (PCAS) at the end of the 2005/2006 fiscal year revealed that the Central LHIN had a score of 58.3 per cent of respondents agreeing that the health care system has improved, or at the minimum remained the same over the past five years. By the third quarter of fiscal 2006/2007, this number was up slightly to 61.3 per cent, which suggests that there is a gradual increase in people agreeing that the health care system is improving.

Doubtless, much work remains for us to sustain and improve public perceptions of the health system. We are committed to improving the health system, and continuing to build public confidence in the system.

"We are committed to improving the health system, and continuing to build public confidence in the system."

Wait Times

Generally, wait times have seen strong improvements during the fiscal year, particularly in the following areas.

Cancer Surgery

Cancer Surgery wait times have improved by 14 per cent over the year with all but one hospital meeting the provincial benchmark.

Cardiac Care

At the end of fiscal 2006/2007, the wait time for Angiography in Central LHIN was ranked third best out of the 14 LHINs and was well below target. Wait time for bypass surgery ranked fourth out of the 14 LHINs, and improved at one of the fastest rates (reduced by 24 per cent in 12 months), and is also well below target. To further improve wait times, the Central LHIN began the formation of a Cardiac Panel and began soliciting membership from hospitals, as well as the Cardiac Care Network (CCN) and Central Community Care Access Centre. This group will have a role that includes identification of issues (including those relating to wait times) and potential solutions and promotion of collaboration and best practice.

Cataract Surgery

Cataract Surgery wait times declined at one of the fastest rates in the province, down 31 per cent over the 12-month average. A new Centre of High Volume, located at the Branson site of North York General Hospital was also established during the year. In this centre, improvements included the establishment of dedicated operating suites designed for the care of cataract patients; standardized operative packs, instruments, and supplies; training of staff in a specialized environment; and fostering partnerships with health care providers from different host organizations.

In fact, all acute hospitals in the Central LHIN (Humber River Regional, North York General, Markham Stouffville, York Central, Southlake Regional, and Stevenson Memorial) are engaged in a planning process to develop options for optimal delivery of comprehensive eye care. For example, another Cataract Centre of High Volume will begin operation in the Medical Arts Building, adjacent to and operated by Southlake Regional Health Centre. This new Centre was specifically designed and is being built for the purpose of cataract surgeries and as an eye centre. The two operating suites will be dedicated to cataract and eye surgery, with ceiling mounted microscopes, specialized staff, standardized supplies and equipment. The program will also collaborate with health care providers from outside the immediate catchment area of the hospital and provide access for referrals through a central contact number.

Collaborations

Initiatives and Identified Opportunities

Clinical leaders from the Central LHIN have organized themselves to discuss system-wide approaches to a variety of services. One of the initiatives they have identified to the LHIN is opthamological services. Vascular services have also been identified as a key collaborative opportunity.

The Central LHIN hospital Chiefs of Staff began to meet on a regular basis to discuss joint clinical collaboration. This group has discussed joint credentialling so that all physicians can work in other hospitals. Further to this, the possibility of a system for on-call coverage between the hospitals has been identified.

Key players including hospitals, the Central CCAC, and Long-Term Care Homes began discussing opportunities to manage challenges resulting from ALC (alternate levels of care) patients. The Central LHIN is facilitating cross sector engagement and one tangible outcome has been the preliminary development of a web-based tool for these groups to manage the placement of ALC clients into long-term care.

Community Engagement

Purpose, Strategies and Outcomes

In February 2006, the Central LHIN finalized a Stakeholder Engagement Strategy (SES) based on stakeholder input to the strategy itself.

As part of its strategy, the Central LHIN has committed itself to ongoing engagement with stakeholders – *defined as anyone who will be affected by, or who has the ability to affect, the activities of the Central LHIN.* This includes members of the public, patients, service providers and others.

The objectives of the SES are to build relationships with stakeholders and provide them with balanced and objective information; obtain feedback and make recommendations on service gaps and opportunities for coordination and integration; and ensure that concerns are consistently understood and considered.

During the 2006-2007 fiscal year, the Central LHIN put the strategy into full effect by successfully establishing, developing and fostering positive stakeholder relationships and encouraging involvement in all aspects of our activities.

Integrated Health Service Plan (IHSP)

Making a Difference:
Helping People Lead Healthier Lives

The most significant outcome of our engagement activities for the past year was the development and release (in October 2006) of our first Integrated Health Service Plan (IHSP). The Plan reflects the broad and extensive input, participation and contribution of our stakeholders — including the many organizations and

providers that deliver health services in our LHIN, health interest groups and associations, and our public, including consumers, patients, clients, and their families and support networks.

Focusing on our system level goals of improving access, coordination, quality and efficiency in the local system, the IHSP development process has helped us to identify our seven health service priority areas:

1. Seniors and specialized geriatric services
2. Mental health and addictions
3. Neurological health services
4. Chronic disease prevention and management
5. Emergency Services
6. Wait lists
7. Cancer Care

Our IHSP is a process, not a product. As such, it lays the foundation for building upon the knowledge base we formed over the past year and establishes the road map for the future. During the development and since its publication, the Central LHIN has continued to expand community engagement efforts.

Our IHSP is a process, not a product.

Prior to the development of the IHSP, the Central LHIN used a variety of engagement methods to encourage input to determine the most appropriate priorities to meet local needs. We invited stakeholders to meet with the LHIN at a series of 14 Community Roundtables in communities across the LHIN in June 2006.

At the Roundtables, 560 stakeholders were involved in structured, focused discussions facilitated by senior staff about the proposed priority areas for our IHSP. In the summer, validation sessions with 100 participants offered health service providers and others the opportunity to respond to and comment on aspects of the draft IHSP. Further input was solicited in the fall, with 400 people attending seven Open Houses in different communities where participants had an opportunity to comment on the draft plan.

Putting the IHSP into Action

Following the submission of the IHSP, in the early winter, LHIN senior management met with the senior management team of each health service provider organization in Central LHIN to present and discuss the plan. Near the end of 2006, a focused engagement with local press led to extensive media coverage in all the major local papers in Central LHIN.

Aboriginals

In Spring 2006, Central LHIN attended an Aboriginal Health Fair on Georgina Island. About 10 providers had displays and Central LHIN distributed materials and a survey for input on our developing priorities. The day provided the LHIN with an opportunity to network with providers and over 50 Aboriginal health care consumers.

Ethnocultural Communities

In the early months of 2007, Central LHIN engaged the faith-based and ethnocultural communities in the LHIN as a way to continue and broaden the

outreach to members of the public. Fifteen sessions, arranged by members of Central LHIN's Regional Stakeholder Group, board members as well as responses to requests from the public, were held with nearly 900 participants to increase awareness about the LHIN and its IHSP.

Family Physicians

Central LHIN engaged with family physicians in a variety of ways. While family physicians are outside the mandate of LHINs, they are essential navigators of the health system and their input was, and will continue to be, sought. In March, the Central LHIN Family Physician Advisory Group held a Think Tank with 30 family physicians to obtain input into the implementation of the priorities identified in the IHSP and to inform family physicians about LHINs and the Central LHIN priorities.

Unions

Part of our stakeholder engagement strategy is to connect with and listen to the perspectives of the labour force and those working on the front lines. Sessions were held with provincial union leadership, individually and as a group, in 2006-2007, and plans to engage with local union leaders are in place for the coming fiscal year.

Reaching Across Communities

During the course of the year, the Central LHIN expanded its engagement activities to include more than 25 different groups led by the Central LHIN. These include the establishment of six priority planning Advisory Networks designed to inform the work the LHIN does to advance its progress in the identified health service priority areas. Most of these groups have one or more working groups that have been established to address specific needs within those priorities.

Also established were four Enabler Advisory Groups including Health Human Resources, IM/IT/eHealth, Decision Support, and Family Physicians, and other planning groups such as the Palliative and End-of-Life Care Network and the Vascular Surgery Services Work Group. Also, the Regional Stakeholder Group continued to inform our stakeholder engagement activities as required. Hundreds of providers, community members and consumers were represented on these groups.

The Central LHIN also participated in numerous engagement activities led by other organizations within the geography that are essential to ensuring a cohesive and integrated health system including a pandemic planning work group.

Communications Strategy

The Central LHIN consulted with thousands of health service providers and members of the public as it developed its first Strategic Plan and Integrated Health Service Plan. Recognizing that a key overarching enabler for all its activities is communications, the Central LHIN created its first Communications Strategy in order to facilitate the continuing dialogue with our stakeholders. The strategy was delivered to and approved by the Board of Directors at the end of the fiscal year. The purpose of the strategy was to "encourage the *sharing* of ideas and information as well as stimulating *support* for and *participation* in the Central LHIN's Mission and Vision."

The goals, principles and stakeholders outlined in the Communications Strategy mirror the Central LHIN Stakeholder Engagement Strategy, as the two core functions are by their nature, intertwined.

Financial Statements of

CENTRAL LOCAL HEALTH INTEGRATION NETWORK

March 31, 2007

Deloitte.

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Canada

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Auditors' Report

To the Members of the Board of Directors of the Central Local Health Integration Network

We have audited the statement of financial position of Central Local Health Integration Network (the "LHIN") as at March 31, 2007 and the statements of financial activities, changes in net debt and cash flows for the year then ended. These financial statements are the responsibility of the LHIN's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In our opinion, these financial statements present fairly, in all material respects, the financial position of Central Local Health Integration Network as at March 31, 2007 and the results of its operations, its changes in its net debt and its cash flows for the year then ended in accordance with Canadian generally accepted accounting principles.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants

Toronto, Ontario
May 3, 2007

CENTRAL LOCAL HEALTH INTEGRATION NETWORK
Statement of Financial Position
March 31, 2007

	2007	2006 (Notes 3, 15)
FINANCIAL ASSETS		
Cash	$ 311,559	$ 33,376
Accounts receivable	232	–
	311,791	33,376
LIABILITIES		
Accounts payable and accrued liabilities (Note 4)	279,936	–
Due to Ministry of Health and Long-Term Care ("MOHLTC")	428	33,376
Due to the LHIN Shared Services Office (Note 5)	34,917	–
Deferred capital contributions (Note 6)	360,436	384,580
	675,717	417,956
NET DEBT	(363,926)	(384,580)
NON-FINANCIAL ASSETS		
Prepaid expenses	3,490	–
Capital assets (Note 7)	360,436	384,580
	363,926	384,580
ACCUMULATED SURPLUS	$ –	$ –

Director

Director

CENTRAL LOCAL HEALTH INTEGRATION NETWORK

Statement of Financial Activities

Year ended March 31, 2007

	2007		2006
	Budget	Actual	Actual
	(unaudited) (Note 8)		(Notes 3, 15)
REVENUE			
MOHLTC funding	$ 3,090,664	$ 3,012,028	$ 195,798
E-Health funding (Note 10)	32,000	32,000	–
End of Life funding (Note 11)	70,000	70,000	–
Amortization of deferred capital contributions (Note 6)	–	102,780	96,146
	3,192,664	3,216,808	291,944
EXPENSES			
General and administrative (Note 9)	3,090,664	3,114,489	291,944
E-Health (Note 10)	32,000	31,979	–
End of Life (Note 11)	70,000	69,912	–
	3,192,664	3,216,380	291,944
ANNUAL SURPLUS BEFORE FUNDING REPAYABLE TO THE MOHLTC	–	428	–
FUNDING REPAYABLE TO THE MOHLTC	–	(428)	–
ANNUAL SURPLUS	–	–	–
OPENING ACCUMULATED SURPLUS	–	–	–
CLOSING ACCUMULATED SURPLUS	$ –	$ –	$ –

CENTRAL LOCAL HEALTH INTEGRATION NETWORK

Statement of Changes in Net Debt

Year ended March 31, 2007

	2007	2006 (Notes 3, 15)
ANNUAL SURPLUS	$ –	$ –
ACQUISITION OF TANGIBLE CAPITAL ASSETS	78,636	480,726
AMORTIZATION OF TANGIBLE CAPITAL ASSETS	(102,780)	(96,146)
CHANGE IN OTHER NON-FINANCIAL ASSETS	3,490	–
(INCREASE) DECREASE IN NET DEBT	(20,654)	384,580
OPENING NET DEBT	384,580	–
CLOSING NET DEBT	$ 363,926	$ 384,580

CENTRAL LOCAL HEALTH INTEGRATION NETWORK
Statement of Cash Flows
Year ended March 31, 2007

	2007	2006 (Notes 3, 15)
NET INFLOW (OUTFLOW) OF CASH RELATED TO THE FOLLOWING ACTIVITIES		
OPERATING		
Annual surplus	$ –	$ –
Less items not affecting cash		
Amortization of capital assets	102,780	96,146
Amortization of deferred capital contributions (Note 6)	(102,780)	(96,146)
	–	–
USES		
Increase in accounts receivable	232	–
Decrease in due to the MOHLTC	32,948	–
Increase in prepaid expenses	3,490	–
	36,670	–
SOURCES		
Increase in accounts payable	279,936	–
Increase in due to the MOHLTC	–	33,376
Increase in due to the LHIN Shared Services Office	34,917	–
	314,853	33,376
CAPITAL TRANSACTIONS		
Acquisition of tangible capital assets	(78,636)	(480,726)
FINANCING TRANSACTIONS		
Increase in deferred capital contributions (Note 6)	78,636	480,726
NET INCREASE IN CASH	278,183	33,376
CASH, BEGINNING OF YEAR	33,376	–
CASH, END OF YEAR	$ 311,559	$ 33,376

CENTRAL LOCAL HEALTH INTEGRATION NETWORK
Notes to the Financial Statements
March 31, 2007

1. DESCRIPTION OF BUSINESS

Formation and status

The Central Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act, 2006* (the "Act") as the Central Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in both the Act and the Memorandum of Understanding between the LHIN and the Ministry of Health and Long-Term Care (the "MOHLTC").

The LHIN has also entered into an Accountability Agreement with the Ministry of Health and Long Term Care which describes the responsibilities of the LHIN and the performance standards that are required to be maintained and achieved in order to obtain funding from the Province.

As of April 1, 2007, funding payments to providers will flow through the LHIN's financial statements. These transfer payments will be reflected as revenue and expenses in the LHIN's financial statements for the year ended March 31, 2008 and thereafter.

LHIN operations

The objects of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers most of North York, York Region and South Simcoe.

2. BASIS OF PRESENTATION

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants ("CICA") and, where applicable, the recommendations of the Accounting Standards Board ("AcSB") of the CICA as interpreted by the Province of Ontario. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of tangible capital assets; and losses in the value of assets.

Expenses include:

- The amortization of tangible capital assets; and
- Losses in the value of assets

2. SIGNIFICANT ACCOUNTING POLICIES (continued)

Ministry of Health and Long-Term Care Funding

The LHIN is funded solely by the Province of Ontario in accordance with budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC.

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Deferred contributions

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Any amounts received that are used to fund expenses that are recorded as tangible capital assets, are recorded as deferred capital revenue and are recognized over the useful life of the asset reflective of the provision of its services. The revenue is in accordance with the amortization policy applied to the related capital asset recorded.

Tangible capital assets

Tangible capital assets are recorded at historical cost. Historical cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of tangible capital assets. The cost of tangible capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed tangible capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the tangible capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a tangible capital asset are capitalized. Computer software is recognized as an expense when incurred.

Tangible capital assets are stated at cost less accumulated amortization. Tangible capital assets are amortized over their estimated useful lives as follows:

Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method
Office furniture and fixtures	5 years straight-line method
Infrastructure/web development	3 years straight-line method

For assets acquired or brought into use during the year, amortization is calculated for a full year

2. SIGNIFICANT ACCOUNTING POLICIES (continued)

Use of estimates

The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

3. ADOPTION OF PUBLIC SECTOR ACCOUNTING RECOMMENDATIONS

At the direction of the MOHLTC, commencing in 2007, the LHIN has adopted generally accepted accounting principles, applying government accounting standards issued by the Public Sector Accounting Board of the Canadian Institute of Chartered Accountants. The comparative figures included in these financial statements have been restated to conform with accounting standards adopted for the current year.

As a result of this change, during the year the LHIN obtained the fair market value for the donated tangible capital assets received in the prior fiscal period and chose to reflect this more meaningful valuation in the financial statements. This change has been applied retroactively and the prior period has been restated resulting in an increase in deferred capital contributions, net debt and capital assets of $384,580 on the Statement of Financial Position. On the Statement of Financial Activities amortization of deferred capital contributions increased by $96,146 as did general and administrative expenses. On the Statement of Changes in Net Debt acquisition of tangible capital assets increased by $480,726 amortization of tangible capital assets increased by $96,146 and closing net debt increased by $384,580.

7. ACCOUNTS PAYABLE AND ACCRUED LIABILITIES

The MOHLTC has included accounts payable and accrued liabilities totaling $198,166 in its records on behalf of the LHIN as at March 31, 2006. These expenses are included in amounts disclosed in Note 9 related to the prior period.

8. RELATED PARTY TRANSACTIONS

The LHIN Shared Services Office (the "LSSO") is a division of the Toronto Central LHIN and is subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO, on behalf of the LHINs is responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs on an equal basis. Any portion of the LSSO operating costs overpaid (or not paid) by the LHIN at the year end are recorded as a receivable (payable) to the LSSO. This is all done pursuant to the Shared Service Agreement the LSSO has with all the LHINs.

6. DEFERRED CAPITAL CONTRIBUTIONS

	2007	2006
Balance, beginning of year	$ 384,580	$ –
Capital contributions received during the year	78,636	480,726
Amortization for the year	(102,780)	(96,146)
	$ 360,436	$ 384,580

7. CAPITAL ASSETS

	2007			2006
	Cost	Accumulated Amortization	Net Book Value	Net Book Value
Office furniture and fixtures	$ 166,884	$ 61,666	$ 105,218	$ 113,154
Computer equipment	4,637	1,546	3,091	–
Leasehold improvements	373,303	135,714	237,589	271,426
Infrastructure/web development	14,538	–	14,538	–
	$ 559,362	$ 198,926	$ 360,436	$ 384,580

8. BUDGET FIGURES

The total budget of $3,090,664 have been approved by the MOHLTC. The figures have been reported for the purposes of these statements to comply with PSAB reporting principles.

9. GENERAL AND ADMINISTRATIVE EXPENSES

For the period ended March 31, 2006, certain operating expenses, other than those disclosed on the Statement of Financial Activities, were approved and paid for on behalf of the LHIN by the MOHLTC. These amounts were not included with the LHIN's financial activities and are disclosed below for information purposes. These expenses are as follows:

Salaries and benefits	$ 139,938
Accommodation/occupancy	1,128,209
Common services	42,126
Information technology	100,609
Other expenditures	388,803
	$ 1,799,685

9. GENERAL AND ADMINISTRATIVE EXPENSES (continued)

For the first three months of fiscal 2007, all financial information was processed by the MOHLTC on behalf of the LHIN. Unlike 2006, these amounts are considered expenses of the LHIN directly and are included as part of the financial activities of the LHIN and included in the Statement of Financial Activities.

As part of this transaction, amounts totalling $78,535 of prior period expenses were not accrued. For the year ended March 31, 2007, these amounts were included in the Statement of Financial Activities of the LHIN.

The Statement of Financial Activities presents the expenses by function, the following classifies these same expenses by object:

	2007	2006
Salaries and benefits	$ 1,415,446	$ 192,496
Occupancy	124,540	–
Amortization	102,780	96,146
Shared services	294,071	–
Public relations	269,329	–
Consulting services	608,219	–
Supplies	58,036	298
Board member expenses	123,828	–
Mail, courier and telecommunications	32,489	–
Other	85,751	3,004
	$ 3,114,489	$ 291,944

10. E-HEALTH

The LHIN received funding of $32,000 related to the E-Health project. The Statement of Financial Activities presents all expenses by project, the following classifies these same E-Health expenses by object:

	2007	2006
Consulting services	$ 25,750	$ –
Supplies	1,062	–
Other	5,167	–
	$ 31,979	$ –

11. END OF LIFE

The LHIN received funding of $70,000 related to the End of Life project. The Statement of Financial Activities presents all expenses by project, the following classifies these same End of Life Project expenses by object:

	2007	2006
Consulting services	$ 60,303	$ –
Supplies	5,032	–
Other	4,577	–
	$ 69,912	$ –

12. PENSION AGREEMENTS

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 14 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2007 was $74,254 (2006 - $14,597) for current service costs and is included as an expense in the Statement of Financial Activities.

13. GUARANTEES

The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act, 2006* and in accordance with s. 28 of the *Financial Administration Act*.

14. COMMITMENTS

The LHIN has commitments under various operating leases related to building and equipment. Lease renewals are likely. Minimum lease payments due in each of the next five years and thereafter are as follows:

2008	$ 177,429
2009	182,310
2010	182,754
2011	182,754
2012 and thereafter	15,230
	$ 740,477

15. COMPARATIVE FIGURES

The prior period figures are from the date of incorporation, June 2, 2005 to March 31, 2006. During the 2007 fiscal year, the LHIN received direction from the MOHLTC in its Memorandum of Understanding to follow PSAB accounting. Presentation changes are a result of the change in presentation format to comply with PSAB.

Central
LOCAL HEALTH INTEGRATION NETWORK
RÉSEAU LOCAL D'INTÉGRATION DES SERVICES DE SANTÉ
du Centre

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ISSN 1911-3374 400 1M June/07 © 2007 Queen's Printer for Ontario

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